CITY OF SANTA BARBARA
PUBLIC WORKS DEPARTMENT
SantaBarbaraCA.gov/PublicWorks

ANNUAL PARKING PERMIT FOR OVERSIZED VEHICLE

APPLICATION - DISABILITY

Residents of the City of Santa Barbara with disabilities may apply for an annual permit to park a disability-specific oversized vehicle adjacent to the location(s) at which they are employed or receiving necessary services.

CONDITIONS

Oversized vehicle disability parking permits shall be valid for so long as the person remains disabled, but for no longer than one year. Permits may be renewed provided th at the permit holder demonstrates in writing that he or she continues to meet the conditions.

- Must attach copy of valid Disabled Parking Placard or registration for disabled plates.
- Must attach copy of valid CA vehicle registration.
- Must include a written statement describing the reasons why the oversized vehicle is necessary to accommodate your disability. Include a description of any modifications to the vehicle to accomodate your disability.

Please fill out and print the form and return it to the Downtown Parking office at 1221 Anacapa Street.

APPLICANT

LAST NAME: ____________________ FIRST NAME: ____________________

PHONE: ____________________ EMAIL: ____________________

HOME ADDRESS: ____
(Number, Street, Unit, Zip Code)

DRIVER'S LICENSE # ____________________ DISABILITY PLACARD # ____________________

VEHICLE

LICENSE PLATE NUMBER: ____________

VEHICLE TYPE: ☐ RV ☐ TRAILER ☐ VAN ☐ TRUCK ☐ OTHER

☐ I CERTIFY THAT I OWN OR LAWFULLY POSSESS THIS VEHICLE

LOCATION(S)

(PLEASE ATTACH EXTRA PAGES IF NEEDED)

FILL OUT ATTACHED FORM TO DEFINE LOCATION(S) WHERE PARKING IS TO BE PERMITTED.

STATEMENT

FILL OUT ATTACHED FORM TO DESCRIBE NECESSITY FOR USE OF OVERSIZE VEHICLE.

I certify under penalty of perjury that all information on this application and supporting documents is true and correct.
Read and executed in Santa Barbara, Ca on:

Signature: ______________________________ Date: ____________

ATTACH ALL DOCUMENTS SPECIFIED IN THIS APPLICATION, INCOMPLETE APPLICATIONS WILL NOT BE PROCESSED.

PARKING STAFF ONLY BELOW LINE

DATE RECEIVED: ____________ TEMP #: ____________ TEMP EXP#: ____________

PERMIT ISSUE DATE: ____________ PERMIT NUMBER: ____________

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LOCATION(S)

Applicants must specify locations or location types where they need to park to receive services.

LOCATION

☐ GOVERNMENT FACILITY ☐ EDUCATION FACILITY ☐ COMMERCE ☐ MY RESIDENCE ☐ EMPLOYMENT
☐ OTHER SERVICE FACILITY: ______

DESCRIPTION: ______

ADDRESS: ______ (Number, Street, Unit)

May use generic location, such as “All Grocery Stores” or “All Post Offices”.
This is the address adjacent to which you will be permitted to park.

CONTACT PHONE: ______

LOCATION

☐ GOVERNMENT FACILITY ☐ EDUCATION FACILITY ☐ COMMERCE ☐ MY RESIDENCE ☐ EMPLOYMENT
☐ OTHER SERVICE FACILITY: ______

DESCRIPTION: ______

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LOCATION

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LOCATION

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LOCATION

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STATEMENT

On your application to the Department of Motor Vehicles for a disability placard, your medical professional certified that you meet the definition of a "disabled person" found in the California Vehicle Code (CVC 295.5). In the form below, please provide the information that was provided by your medical professional on your disability placard application. If you are unwilling or unable to provide this information, the City may request this information from the Department of Motor Vehicles per CVC 22511.58. Your application may be delayed as we wait for a response from the DMV.

☐ A lung disease to the extent that forced (respiratory) expiratory volume for one second when measured by spirometry is less than one liter or arterial oxygen tension (pO2) is less than 60 mm/Hg on room air while the person is at rest.

☐ A cardiovascular disease to the extent that the person's functional limitations are classified in severity as class III or class IV based upon standards accepted by the American Heart Association.

☐ A diagnosed disease or disorder which substantially impairs or interferes with mobility due to (please print):

____

☐ A severe disability in which he or she is unable to move without the aid of an assistive device, which is due to (please print):

____

☐ A significant limitation in the use of lower extremities due to (please print):

____

☐ The loss, or loss of the use of one or more lower extremities. Loss of use due to (please print):

____

☐ The loss, or loss of use of, both hands. Loss of use due to (please print):

____

☐ Central visual acuity does not exceed 20/200 in the better eye, with corrective lenses, as measured by the Snellen test, or visual acuity that is greater than 20/200, but with a limitation in the field of vision such that the widest diameter of the visual field subtends an angle not greater than 20 degrees.

➡ Please indicate how your vehicle has been specifically modified or is necessary to accommodate the disability certified by your physician, and how the size of the vehicle is necessary for this modification.

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PARKING STAFF ONLY BELOW LINE

PERMIT NUMBER: ____________________